Virginia Department of Health
TB Intake Sheet

WebVision # **ICD9#**

Last Name_____ _____First Name_____ Middle_____
Birth Date___ / /___ Race___ Sex____ Marital status_____Parent/Guardian _____
Home Address_____ Apt # _____
City_____ State_____ Zip_____
Home Phone _____ Work Phone:_____Cell Phone _____
Country of Origin _____ Year of arrival _____ Preferred Language _____
Provider _____ Provider Phone _____
Reporting Source _____ Reporter Phone _____

TB Symptoms (Check all that apply. May skip section and complete Health History form if from patient interview)
_____None
_____Cough ≥ 3 weeks
_____Productive? Y N Hemoptysis? Y N
_____Fever, unexplained
_____Unexplained weight loss
_____Poor appetite
_____Night Sweats
_____Fatigue

Additional Individual Risk for Infection (Check all that apply)
_____ Identified Contact (Case_____)
_____ ≥ 3 months in high prevalence country
_____ Resident/employee congregate setting
_____ Medically underserved
_____Uses illegal drugs

Individual Risk for Progression to Disease
_____HIV infection
_____ Medical conditions that increase risk (diabetes, ESRD, Cancer, 10% below ideal weight, etc.)
_____ History of inadequate TB treatment
_____ Immunosuppressive therapy (steroids, cancer treatment, include treatment for Rheumatoid Arthritis such as Remicade, Humira, etc.)

Site: ___ Pulmonary ___ Extra-pulmonary
Specify:

Initial blood work? ☐ Yes ☐ No Report: ☐ Yes ☐No
LMP EDD BCG ☐ Yes ☐ No

TST Results
Date Given _____ Date Read _____
Induration_____mm ☐ Positive ☐ Negative

Current Chest x-ray **Date** _____
Location of film: _____ Addl. Old Films: Y N
☐ Negative ☐ Abnormal ☐ Cavitary
Describe:

HIV Testing
___ Not Tested
___ Tested
___ Negative
___ Positive
___ Results pending
Date _____

Other Info
Hospitalized: Y N
Where?
Room # _____

Initial Bacteriology (Check for susceptibility if lab not DCLS)

Date	Smear	Culture	Sensitivity

Current Treatment Regimen ☐ **DOT** ☐ **Self**

Drug	Dosage	Frequency	Start Date	Stop Date

Additional Comments (additional treatment information, work site, school, living arrangements, other activities)
Class B Immigrant/Refugee? ☐ Yes A # _____

Date _____ Completed by _____

Clinician Orders

☐ Isoniazid _____ mg P.O. Qd BIW TIW x _____ doses
☐ Rifampin _____ mg P.O. Qd BIW TIW x _____ doses
☐ Pyrazinamide _____ mg P.O. Qd BIW TIW x _____ doses
☐ Ethambutol _____ mg P.O. Qd BIW TIW x _____ doses
☐ Pyridoxine _____ mg P.O. Qd BIW TIW x _____ doses
☐ Meds by DOT
☐ Sputum collection protocol
☐ Blood work Specify: _____

Date _____

Clinician Assessment/Progress Notes

Clinician Signature _____